Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
LIBERTY INSURANCE CORPORATION

Carrier's Austin Representative Box
Box Number 1

MFDR Tracking Number
M4-10-1257-01

MFDR Date Received
October 23, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On or about January 05, 2009, Provider submitted a bill requesting 'Separate Reimbursement to Hospital for Implantables Requested.' We are not requesting separate reimbursement for implants. . . . On April 29, 2009, Provider sent Carrier a Request for Reconsideration noting that Carrier failed to reimburse Provider pursuant to the appropriate sections of the fee guideline applicable when provider does not request separate reimbursement for implantables . . . It is unclear from the Explanation of Benefits what methodology Carrier used to calculate reimbursement, but because Provider does request that the implantables be paid separately, Carrier should have reimbursed Provider pursuant to section 134.403(f)(1)(A). Carrier has severely under-reimbursed Provider by either applying the inappropriate reimbursement methodology or inappropriately calculating reimbursement under the applicable rule."

Amount in Dispute: $3,683.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "To support extensive debridement (29823), the documentation should support work in BOTH the front and back of the shoulder. This is per the American Association of Orthopedic Surgeons. . . . CPT 20926 is defined as Tissue grafts, other (eg, paratenon, fat, dermis). The provider billed this code for Placing platelet gel into the operative site for healing; this does not fit the definition of this code and would be incidental to the primary code billed. . . . Liberty Mutual believes that Vista Hospital of Dallas has been appropriately reimbursed for services rendered . . ."

Response Submitted by: Liberty Mutual, 2875 Browns Bridge Road, Gainesville, Georgia 30504

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 2008	Outpatient Hospital Services	$3,683.44	$3,683.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X936 – CPT OR HCPC IS REQUIRED TO DETERMINE IF SERVICES ARE PAYABLE. (X936)
   - X901 – DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED. (X901)
   - Z652 – RECOMMENDATION OF PAYMENT HAS BEEN BASED ON A PROCEDURE CODE WHICH BEST DESCRIBES SERVICES RENDERED. (Z652)
   - Z710 – THE CHARGE FOR THIS PROCEDURE EXCEEDS THE FEE SCHEDULE ALLOWANCE. (Z710)
   - U849 – THIS MULTIPLE PROCEDURE WAS REDUCED 50%% ACCORDING TO FEE SCHEDULE OR USUAL AND CUSTOMARY GUIDELINES. (U849)
   - B398 – THIS PROCEDURE IS INCLUDED IN THE PRIMARY PROCEDURE. (B398)
   - B207 – THIS IS AN UNLISTED PROCEDURE. PLEASE RESUBMIT WITH A MORE DESCRIPTIVE CODE. (B207)
   - U634 – PROCEDURE CODE NOT SEPARATELY PAYABLE UNDER MEDICARE AND OR FEE SCHEDULE GUIDELINES. (U634)

Issues

1. Did the respondent support the insurance carrier's reasons for denial of procedure code 29823?
2. Did the respondent support the insurance carrier's reasons for denial of procedure code 20926?
3. Are the disputed services subject to a contractual agreement between the parties to this dispute?
4. What is the applicable rule for determining reimbursement for the disputed services?
5. What is the recommended payment amount for the services in dispute?
6. What is the additional recommended payment for the implantable items in dispute?
7. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed procedure code 29823 with reason code X901 – "DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED." The respondent's position statement asserts that "To support extensive debridement (29823), the documentation should support work in BOTH the front and back of the shoulder. This is per the American Association of Orthopedic Surgeons." Per 28 Texas Administrative Code §134.403(d), for coding, billing, reporting, and reimbursement of covered health care, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service. Per Medicare's Program Integrity Manual §3.3 A and B, "The primary authority for all coverage provisions and subsequent policies is the Social Security Act. The MACs, CERT, Recovery Auditors, and ZPICs shall use Medicare policies in the form of regulations, CMS rulings, national coverage determinations (NCDs), coverage provisions in interpretive Medicare manuals, local coverage determinations (LCDs) and MAC policy articles attached to an LCD or listed in the Medicare Coverage Database to apply the provisions of the Act…an item/service is correctly coded when it meets all the coding guidelines listed in the Current Procedural Terminology-4 (CPT) book, ICD-9, HCPCS and CMS policy or guideline requirements, LCDs, or MAC articles." The American Association of Orthopaedic Surgeons is not listed as an authority with regard to Medicare documentation requirements. No information was found to support that Medicare requires documentation for extensive debridement must support work in both the front and back of the shoulder. Moreover, per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." The requestor's operative notes page 14 documents extensive arthroscopic debridement performed. Review of the submitted medical records finds that the submitted documentation supports the service as billed. The insurance carrier's denial reason is not supported. The disputed service will therefore be reviewed per applicable Division rules and fee guidelines.
2. The insurance carrier reduced or denied disputed procedure code 20926 with reason code X901 – "DOCUMENTATION DOES NOT SUPPORT LEVEL OF SERVICE BILLED." The respondent's position statement asserts that "CPT 20926 is defined as Tissue grafts, other (eg, paratenon, fat, dermis). The provider billed this code for Placing platelet gel into the operative site for healing; this does not fit the definition of this

code and would be incidental to the primary code billed." The respondent did not submit sufficient documentation to support its assertion that the disputed service does not fit the definition of the procedure code billed and/or would be incidental to the primary code billed. Moreover, per 28 Texas Administrative Code §133.307(d)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Review of the requestor's operative report page 16 finds sufficient documentation to support the service as billed. The disputed service will therefore be reviewed per applicable Division rules and fee guidelines.

3. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Although the requestor's position statement asserts both that "We are not requesting separate reimbursement for implants," and "Provider does request that the implantables be paid separately," review of the submitted documentation finds clear indication that separate reimbursement for implantables was requested. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $10,020.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
4. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code J3490 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.
   - Per Medicare policy, procedure code A4649 represents an item or service for which payment is bundled into payment for other services billed on the same date of service. Separate payment is not recommended.
   - Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.31. 125% of this amount is $4.14. The recommended payment is $4.14.
   - Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,746.76. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,714.62. The non-labor related portion is 40% of the APC rate or $1,164.51. The sum of the labor and non-labor related amounts is $2,879.13. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $3,205.75 yields a cost of $1,045.07. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $2,879.13 divided by the sum of all APC payments is 48.50%. The sum of all packaged costs is $18,316.38. The allocated portion of packaged costs is $8,883.09. This amount added to the service cost yields a total cost of $9,928.16. The cost of this service

exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $4,889.68. 50% of this amount is $2,444.84. The total APC payment for this service, including outliers and any multiple procedure discount, is $5,323.97. This amount multiplied by 130% yields a MAR of $6,921.16.

- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,746.76. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,714.62. The non-labor related portion is 40% of the APC rate or $1,164.51. The sum of the labor and non-labor related amounts is $2,879.13. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $3,205.75 yields a cost of $1,045.07. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $1,439.57 divided by the sum of all APC payments is 24.25%. The sum of all packaged costs is $18,316.38. The allocated portion of packaged costs is $4,441.56. This amount added to the service cost yields a total cost of $5,486.63. The cost of this service exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,967.38. 50% of this amount is $1,483.69. The total APC payment for this service, including outliers and any multiple procedure discount, is $2,923.26. This amount multiplied by 130% yields a MAR of $3,800.24.
- Procedure code 29823 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0042, which, per OPPS Addendum A, has a payment rate of $2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,746.76. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $1,714.62. The non-labor related portion is 40% of the APC rate or $1,164.51. The sum of the labor and non-labor related amounts is $2,879.13. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $3,205.75 yields a cost of $1,045.07. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $1,439.57 divided by the sum of all APC payments is 24.25%. The sum of all packaged costs is $18,316.38. The allocated portion of packaged costs is $4,441.56. This amount added to the service cost yields a total cost of $5,486.63. The cost of this service exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $2,967.38. 50% of this amount is $1,483.69. The total APC payment for this service, including outliers and any multiple procedure discount, is $2,923.26. This amount multiplied by 130% yields a MAR of $3,800.24.
- Procedure code 20926 has a status indicator of T, which denotes a significant procedure subject to multiple procedure discounting. The highest paying status T APC is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. This service is classified under APC 0135, which, per OPPS Addendum A, has a payment rate of $288.30. This amount multiplied by 60% yields an unadjusted labor-related amount of $172.98. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $169.80. The non-labor related portion is 40% of the APC rate or $115.32. The sum of the labor and non-labor related amounts is $285.12. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers and any multiple procedure discount, is $142.56. This amount multiplied by 130% yields a MAR of $185.33.
- Procedure code 94762 has a status indicator of Q, which denotes packaged services that may be separately payable only if OPPS criteria are met. Payment for this procedure is packaged into the payment for any other procedures with status indicator T billed on the same date of service. Review of the submitted information finds that OPPS criteria for separate payment have not been met. Payment for this service is included in the payment for other status indicator T services billed on the same date of service. The use of a modifier is not appropriate. Separate reimbursement is not recommended.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code 94799 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. This service is classified under APC 0367, which, per OPPS Addendum A, has a payment rate of $36.16. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.70. This amount multiplied by the annual wage index for this facility of 0.9816 yields an adjusted labor-related amount of $21.30. The non-labor related portion is 40% of the APC rate or $14.46. The sum of the labor and non-labor related amounts is $35.76. The cost of this service does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $35.76. This amount multiplied by 130% yields a MAR of $46.49.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

5. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
   - “ANCHOR PANALOCK/LUPI" as identified in the itemized statement and labeled on the invoice as "RC loop anchor w/orthocord" with a cost per unit of $363.00 at 6 units, for a total cost of $2,178.00.
   - Additionally, the health care provider billed for a "CENTRIFUGE SEPARATOR" as identified in the itemized statement and labeled on the invoice as "PRP Centrifuge and Cell Separator.” Per §134.403(b)(2), "Implantable" means an object or device that is surgically: (A) implanted, (B) embedded, (C) inserted, (D) or otherwise applied, and (E) related equipment necessary to operate, program and recharge the implantable. Review of the submitted documentation finds insufficient documentation to support that this item meets the definition of an implantable under §134.403(b)(2). Separate reimbursement is not recommended.

   The total net invoice amount (exclusive of rebates and discounts) is $2,178.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $217.80. The total recommended reimbursement amount for the implantable items is $2,395.80.
6. The total allowable payment for the services in dispute is $17,153.40. This amount less the amount previously paid by the insurance carrier of $8,096.70 leaves an amount due to the requestor of $9,056.70. The requestor is seeking $3,683.44. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,683.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,683.44, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	September 28, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please**

include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.